

THE  
LOUISVILLE MEDICAL NEWS.

"NEC TENUI PENNA."

SATURDAY, FEBRUARY 14, 1885.

Original.

PERITYPHILITIS.

BY W. C. DUGAN, M. D.

*Assistant Physician to the Central Kentucky Lunatic Asylum.*

[CONCLUDED.]

From some cause my patient's appendix became distended with fecal matter, being unable to discharge its contents as it had habitually done in health. Gradually a part of this material, in consequence of an imperfect peristalsis, began to form those seed-like bodies which were found post-mortem, some two or three in number, impacted in the appendix. These bodies fretted and irritated the mucous membrane until inflammation was established. Plastic lymph was thrown out, binding the appendix with the cecum to the fascia covering the quadratus lumborum muscle, so preventing peritoneal perforation which would have excited either general acute and fatal peritonitis or a circumscribed peritoneal abscess. The inflammation of the appendix vermis continued after the latter had been bound by plastic lymph to the fascia, until perforative ulceration followed with an escape of part of its contents into the "tissue of inflammatory new formation," which was the nucleus of the subsequent large abscess. This abscess, constantly receiving fecal matter through the perforation, became larger, and its wall became thinner, because of the continual pressure from within, until, under the straining at stools induced by a dose of liquid Crab-Orchard salts, it ruptured. The time at which the abscess began can be but a matter of conjecture, but I am of the opinion that it was of several weeks' or even months' duration.

Up to the time of the rupture of the ab-

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scess, the patient was apparently in perfect health. He was six feet high, weighed two hundred and six pounds, and physically seemed to be a model man. Since his death I have learned from an intimate friend of his that for several months he had had a recurring sensation of uneasiness in his bowels, for the relief of which he had been in the habit of taking salts.

When the abscess ruptured, its contents became partially diffused into the sub-peritoneal tissue, exciting cellulitis with a circumscribed peritonitis and marking the invasion of the disease. The temporary lull of the symptoms on the second day was the result of nature's attempt to arrest the disease; but this was insufficient, and as a result general peritonitis followed on the evening of the third day. Most of these cases terminate in this way. The history of a persistent, vague uneasiness in the bowels may be regarded as highly symptomatic of the disease. When this abscess became large it pressed upon the lumbar plexus of nerves, causing numbness, formication, and paresis of the right leg; and upon the genito-crural nerve of that plexus, the genital branch of which supplies the cremasteric muscle with motor power, causing retraction of the testicle, swelling, and at last an entire disorganization of that gland.

Retraction of the testicle seems to be very rarely met with in this disease, since I have not been able to find among the many reports at hand a single case in which it was noticed. This phenomenon is a prominent symptom in diseases of the genito-urinary tract, especially calculus; not occurring to my knowledge in the disease under consideration. I was at first misled by it, as the report shows. On the second day I made a diagnosis which proved to be correct, and explained the delusive symptom (retraction of the testicle) upon the theory that the abscess was so situated as to irritate

the genito-crural nerve. On post-mortem the nerve was found to pass across the floor of the abscess.

The swelling and disorganization of the testicle resulted from the gland being so tightly drawn up into the external abdominal ring, that the return of blood through the spermatic veins was prevented.

If the patient can withstand shock and the subsequent peritonitis, the abscess will point as do other pelvic abscesses. I am quite sure that most surgeons and physicians have met with just such a case as I have reported, which terminated in a similar way. I am aware of the widespread timidity of surgeons and physicians, especially the latter, upon the question of opening the abdomen. The younger members of the profession, however, are less prejudiced than the older, who are prone to adhere to the old doctrine of conservatism. There is certainly very little danger in opening the abdominal cavity, if the great precaution of the nineteenth century be observed.

Concerning the treatment, Dr. Ashhurst says: "The treatment consists in making a free incision as soon as the occurrence of pointing renders it probable that adhesion has taken place between the peritoneum and the wall of the abscess." Dr. Flint says: "The abscess should be opened as soon as the nature of the case is determined, without waiting for the formation of pus." Mr. Hancock, of London, in 1848, advised this early operation. Dr. W. Parker performed it in 1867, and since it has been performed by Buck, Sands, Weber, and others. Dr. Sands prefers the operation proposed by Dr. Parker, which is as follows: An incision is made two inches long, parallel to Poupart's ligament over the tumescent region. After dividing cautiously the abdominal wall to the level of the fascia transversalis, the hypodermic syringe should be used for exploration to determine the exact locality of the abscess. Then a deep incision one half inch in length completes the operation. Some surgeons prefer to cut down to fascia transversalis only, leaving the pus to discharge spontaneously, so obviating the risk of opening the peritoneum. But if the dissection is carefully made the fascia can be opened without injuring this membrane.

All the operations as yet practiced, so far as I have been able to ascertain, have but the one object to accomplish, the evacuation of the abscess, none designedly to secure the perforated appendix and cleanse the old abscess. The mortality of the disease

as it ran under the treatment of venesection, purgatives, and opium has been much lessened by the procedure proposed by Mr. Hancock, and practiced by himself and others. When the abscess is evacuated it may in a short time heal by granulation, leaving the patient well. I am of the opinion, however, that many of these cases which heal so readily after the operation are not the result of perforation of the appendix, from the fact that an abscess with such cause and relation would in most cases assume the chronic form, with constantly recurring fecal and gaseous discharges from the intestinal tract through the perforated appendix. If the perforation be large it may become attached to the surrounding tissue, and a fecal fistula be the result. But even if the abscess heals, and the perforation be temporarily walled in by inflammatory products, the patient is liable to further perforation, abscess, and peritonitis. The procedure advised by Mr. Hancock seems not to be based upon sound scientific principles, since it is designed to relieve the consequence rather than the cause of the disease, and is not abreast with the abdominal surgery of the present day. Theoretically, but founded upon the results of recent advances in abdominal surgery, it occurs to me,\* as it has no doubt to many others, that the most expedient and radical operation would be to cut down upon the appendix and remove the diseased portion of it, dressing the stump as I will describe when giving the details of the operation. In performing this operation the strictest antiseptic precautions should be taken either by means of the carbolized spray or irrigation with the bichlor. sol. 1 to 1000. The cavity of the abscess should be thoroughly cleansed with some antiseptic solution and the abdominal wound closed as after an ovariotomy. I would use chloroform as the anesthetic. The incision should be commenced just external to the deep epigastric artery and immediately above Poupart's ligament. It should extend upward and outward parallel with it to near the ant.-sup. spi. process of the ilium, when the incision must be curved toward the umbilicus and extended until it is five inches in length. It can be lengthened if necessary during the operation. The parts should be divided cautiously to the level of fascia transver-

\*Since writing this paper, I have been informed that a radical operation for the removal of the perforated appendix has been recently devised and successfully performed in England, but to this date I have not been able to find any published account of it.

salis, which should not be opened until all hemorrhage has been arrested. If this precaution were not observed, the next step of the operation would be seriously embarrassed, as the tissue would be altered beyond recognition.

Before opening the fascia the deep circumflex iliac artery should be searched for, and if found exposed and ligated, otherwise the vessel would give troublesome hemorrhage. When the fascia is opened the subserous areolar tissue is brought into view, which should be separated from the peritoneum with the handle of the scalpel until the cecum is reached, behind which is situated the abscess. Too much care can not be exercised, in performing this part of the operation, to avoid opening the peritoneum, for if opened some of the contents of the abscess would gain entrance into the peritoneal cavity and subject the patient to the risk of peritonitis. The abscess should be opened and its cavity thoroughly cleansed before the peritoneum is opened. The peritoneum should then be opened at the most dependent part by lifting it up with a tenaculum and making the opening with a pair of blunt-pointed scissors. In order to get to the appendix the cecum should be raised up, so that the incision can be made behind it. The appendix should then be brought out through the opening in the peritoneum and separated from its mesentery. A ligature should be passed around it near the cecum and of just sufficient tightness to prevent the contents of the cecum from passing out when the diseased portions are removed. Then, if the perforation was not too near the cecum, the appendix should be amputated, say one inch from its base. The proximal end should be cleansed with some antiseptic solution, and its lining membrane cauterized. The heat should be just sufficient to excite enough inflammation to be followed by a rapid effusion of lymph to agglutinate the mucous surfaces of the appendix and to destroy its secretory function. By this procedure we may hope to get union of two mucous surfaces, which otherwise would fail to unite.

The distal end of the stump should then be closed with cat- or fish-gut sutures, five or six in number, and there should also be several used to close the proximal end, but not of sufficient tightness to produce strangulation of the part beyond. When the stump has been thus dressed the ligature around its base should be reduced. I

would take this precaution to secure union throughout its whole length. If any doubt be entertained in regard to the union of the cauterized mucous surfaces, it is best to invaginate the ends of the amputated appendix. If there is no oozing from the cut end or from the stitched wounds, the stump of the appendix should be placed back in the peritoneal cavity and the opening in the peritoneum closed with a continued cat-gut suture. An elliptical piece of the peritoneum should be removed to get rid of that portion of it to which the appendix was attached, and the opening closed as before. A drainage-tube should be introduced and the abdominal wound closed. As soon as the operation has been completed the patient should be put to bed and kept semi-narcotized for five or six days, when as a rule the walls of the appendix will have united. His diet should consist of milk.

I like the incision described better than opening the abdomen in the median line; first, for the reason that the abscess is in the majority of cases in the posterior sub-peritoneal tissue, which can be evacuated without opening the peritoneal cavity, and second, the peritoneum is not so extensively injured, while at the same time the opening is in the most dependent portion, which will readily drain through the abdominal wound.

If, however, I were led to conclude that the abscess was within the peritoneal cavity, or if there was any doubt as to the exact locality of the abscess, or if from the obscurity of the symptoms I was unable to say what the exact lesion was, yet the symptoms being sufficiently grave to warrant an operation, I would make the incision in the median line, as it gives a better opportunity to cleanse the peritoneal cavity, or to inspect the abdominal organs in case no diagnosis had been made.

It is not always possible to differentiate between this disease and obstructive diseases of the bowels, such as internal strangulation, valvular-gall-stone intussusception, but fortunately these conditions are more successfully treated by early abdominal section than by any other method, hence inability to diagnose the exact condition in all cases can not be raised as an objection to the operation but rather as favoring an exploratory operation in the median line.

Several authors advise operations for the diseased portion of the appendix when accidentally found ulcerated in an abscess. Mr. Morris, of the Middlesex Hospital,

London, when speaking of scrotal abscess, says:

"When the abscess has been caused by the appendix ceci in a hernial sac, the treatment would be to remove the diseased portion of the appendix and then to close by sutures the cut extremity, taking care to invaginate the walls so as not to bring two mucous surfaces into apposition by stitches."

Dr. Burchard advises that abdominal section be performed when perforation has taken place into the peritoneal cavity, the cavity cleansed and the appendix stitched to the external wound. The appendix has often been found atrophied, hence it has no important part to play in alimentation.

Mr. Morris says:

"Paland mentions the case of a girl, aged twelve, who, after a few days of general weakness and loss of appetite, was found dead in bed. On post-mortem was found ulceration and perforation of the appendix, in which was found a leaden foreign body making its way out."

"Years ago," he (Morris) continues, "I saw, in the practice of my father, a young lady, aged eighteen, suffering the most intense peritonitis, with symptoms suggestive of intestinal obstruction. She died, and on examination a damson-stone was found in the appendix ceci, the extremity of which was destroyed."

In connection with this he goes on to say:

"All cases for the most part end fatally from acute suppurative peritonitis set up by ulceration and perforation of the coats of the appendix."

It is now generally conceded by most surgeons that traumatic perforations of the bowels are more successfully treated by an early abdominal section and a closure of the wounds of the intestines than by the let-alone or expectant method of treatment.

Resection and circular suture of the intestines have recently largely been practiced both for gangrenous hernia and false anus. Pyloreotomy or partial gastrectomy, first practiced by Péan, of Paris, in 1879, has since been most extensively practiced by German surgeons. Its sphere of usefulness is growing greater. It was first devised to remove carcinoma of the pylorus, but has since been employed to remove ulcers of the stomach, etc.

If these operations are justifiable, the one that I have proposed for the radical cure of perityphlitis, which I have demonstrated on the cadaver twice, must be equally if not more so. The domain of abdominal surgery is certainly becoming vast, and its results being satisfactory, I think a more radical and expedient operation than has hitherto been practiced

should be resorted to in the treatment of perforative ulceration of the appendix, hence my excuse for writing this paper.

It is only too often a question in these cases of giving the patient the benefit offered by an operation or leaving him to die at the mercy of accident. I consider this one of the class of cases in which "cautious boldness" should be practiced and considered something more than "surgical exercise." "When there is intelligent doubt, skillfully operate" is the proper maxim for guidance in dealing with these cases.

I could wish that this paper were more worthy of publication, but if I am successful in directing the attention of the profession to this yet imperfectly explored part of abdominal surgery, it is all that I could expect, it is all that I could desire.

ANCHORAGE, KY.

#### TREATMENT OF COLD ABSCESS, WITH THREE ILLUSTRATIVE CASES.\*

BY AP MORGAN VANCE, M. D.

My object in reporting these cases is to show how much can be done by the proper use of the aspirator in getting rid of collections of pus in the cold condition wherever found, and especially collections in and about the abdominal cavity.

CASE 1. Mr. C., aged twenty-six, was referred to me in the fall of 1882, by Dr. J. W. Holland. His history was strumous, and he had been suffering for several months with uncertain pains about the right hip-joint and anterior part of thigh, which were especially severe in walking. The patient was on crutches, and while standing the thigh was flexed and slightly abducted, with three-quarter-inch atrophy; while in the recumbent position no motion was retarded.

Some tenderness along the anterior crural nerve was found on this side. His general condition was good, but he stated that he had had gonorrhea six years before, with a suppurating bubo on the right side. In this situation a small scar was found.

While palpating over this with a view to finding a cause for the nerve trunk tenderness, I discovered a tumor the size of a turkey's egg in the right iliac fossa, the subject being so fat that it was found only by deep pressure.

\*Read before the Louisville Medico-Chirurgical Society, January 23, 1885. See page 108.

The next day Dr. Geo. W. Ryan, of Cincinnati, saw the case with Dr. Holland and myself. By exclusion a diagnosis of cold abscess was made, notwithstanding the very robust condition of the patient. I aspirated, drawing off nearly a pint of sero-pus.

Four days after this the patient developed intense malarial intermittent fever, which was relieved by large doses of quinine. In ten days the aspiration was repeated, at which time rather less pus was drawn off than at the first attempt. The sac was washed out with a ten-per-cent solution of Listerine, two needles being primarily introduced, the second acting as an outlet for the injected solution. Rapid improvement of all symptoms ensued, and within a month the man was able to go a bird-shooting. I have seen him frequently in the past year; he is still well.

**CASE II.** *Pott's Disease, Mid. Dorsal; Large collection of pus in right psoas muscle; Repeated aspiration; Cure.* Willie Riley, aged nine, had been under my care since early part of 1881. He was referred to me by Dr. Geo. W. Griffiths. Child progressed well as to the spinal trouble, until the fall of 1883, two and a half years, with no increase of deformity.

I had not seen him for six months, when he walked into my office evidently in great physical distress. An examination revealed the right thigh flexed, abdomen much distended, the right iliac fossa and abdomen filled with pus. The child was greatly reduced in flesh. The aspirator needle was immediately introduced just inside the anterior superior spinous process of the ilium, and nearly two quarts of pus were drawn off.

The boy was put on his back and ordered the best of food, frequent milk punches, and extract of malt and iron. Two weeks later an aspiration removed over a quart of pus. Six aspirations at two weeks' intervals were performed in this case, the child improving greatly in health, and growing very fat and rosy. The quantity of pus obtained decreased at each aspiration, until only a half gill of serum came away, the last introduction of the needle failing to find fluid, though by deep pressure a small lump could be felt at the site of the abscess. This case has since had no refilling or other trouble.

**CASE III.** *Abscess in the right iliac fossa (in a boy) cured by two aspirations.* Frank N., aged twelve, was referred to me by Dr. Turner Anderson, in the summer of 1884,

with the following history: Three months before I saw him he had come to Dr. A. complaining of pain accompanying the latter part of the act of micturition, at times passing a little blood and mucus. Under treatment he was soon apparently well, and was not heard of by Dr. Anderson till the day before the case was turned over to me. At this time he was much emaciated. He was irritable, had no appetite, and slept badly. He walked with difficulty, because of the marked flexion of the thigh on the right side, extension being resisted at a point past 90°. Further flexion was easily made, and adduction and abduction were present.

A large collection of fluid could be made out without difficulty, extending down into the pelvis and high up in the loin, the patient having fever which increased in the evening. I aspirated with a needle of the ordinary size, just inside the anterior superior spinous process of the ilium as in Case II, and half a pint of pus was evacuated, when it became so thick that it would not pass through the needle. On the next day a trocar and cannula were introduced, so arranged that the tube of the aspirator could be attached, and a quart of thick, tough,ropy pus was taken away, followed by a little blood upon increased suction.

Ten days after this the procedure was repeated, in which I was assisted by Dr. McGuire, and a little less than a quart of the same sort of pus was drawn off. From the first visit milk punch, *ad lib.*, was ordered with tinct. ferri chlor. in ten-drop doses. After the first evacuation the boy improved rapidly, and in six weeks was well, continuing so till this time.

In conclusion I will simply say that, judging from my own experience, Cases II and III would have proved fatal if the abscesses had been opened by the knife. Case I would have recovered treated by either method. The aspirator, of course, did the work in a much more comfortable and cleanly way, requiring less time. We all know how long these abscesses often are in healing when they do not drain the patient to death.

LOUISVILLE, KY.

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DR. AMBROSE L. RANNEY, Professor of Applied Anatomy in New York Post-Graduate Medical College, has been appointed to fill the chair of anatomy in the University of Vermont, made vacant by the death of Prof. Darling.

## Miscellany.

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**ABSCESS OF THE LIVER.**—In a paper read before the New York State Medical Association, and published in the New York Medical Journal, February 7, 1885, Dr. Janeway says abscess of the liver is more common in this country than is generally supposed. The symptoms are frequently misleading, and good clinical observers often fail to detect its presence. Within the past year seven cases have come under my notice. In summing up attention is drawn to the following points in reference to the subject:

1. Abscesses of the liver can practically be divided into those affecting the left lobe, or the lower part of the right lobe, so that the abscess when formed produces an elastic or fluctuating tumor below the free borders of the ribs, and of those situated in the upper or posterior portion of the right lobe. The reason for this division is that abscesses in the two former situations are easy of access, of diagnosis, and of operative interference. The abscess in the last-mentioned situation is the one which more often gives rise to difficulty in diagnosis, or, if diagnosed, to doubt as to the best and safest methods of interference.

2. There are several methods by which the existence or non-existence of adhesions between the liver and abdominal wall can be made out. The presence of hepatic friction, audible or tactile, shows the absence of adhesions, but the probability that they will soon be formed. If on palpation the edge of the liver remains fixed, and does not descend with respiration, adhesions have in all probability taken place. Again, a long needle—that of a hypodermic syringe or aspirator—introduced into the liver will, if the outer end is left projecting some distance, move upward as the liver descends, and downward as the liver ascends, if no adhesions exist. But if these have formed, then the needle does not move.

3. The difficulties which arise in the diagnosis of liver abscess may in many cases be surmounted by a careful survey of the history of the condition of the liver, and by exclusion of the existence of sufficient disease in other organs to account for the symptoms.

The mistakes which I have seen made have been:

a. To consider a liver abscess some other

disease, as malarial fever (remittent and intermittent), typhoid fever, or tuberculosis.

b. To consider an abscess of the liver some other disease of the liver, as hydatids, cancer, congestion, fatty liver, hyperplasia.

c. To consider the swollen liver an aneurism of the aorta, especially in case of abscess of the left lobe of the liver, where pulsation was communicated to it by the aorta.

d. To consider an abscess of the gall-bladder an abscess of the liver, and *vice versa*.

e. To consider a supra-hepatic abscess an abscess of the liver.

f. To consider an abscess of the liver one of the abdominal wall, and *vice versa*.

Some years since the writer had supposed that a distinction could be made between liver abscess and cancer of the liver by careful attention to the patient's temperature; but subsequent investigation has shown that in cases of rapidly growing or disseminating cancers a hectic type of temperature may exist.

4. As regards the etiology of liver abscess I believe that many of the apparently idiopathic are of traumatic origin. I have in several instances ascertained its occurrence in persons who were in the habit of lifting heavy weights, particularly those who did so in hot places, as firemen, those unloading vessels, etc., by placing the right elbow firmly against the side, and then having the weight raised in this way. By this statement I do not mean to deny the probable influence of bacteria in the origination of abscesses, but to attribute to traumatism the establishment of that favorable condition which will allow of abscess formation.

In concluding I might add to this paper, which is intended to present the subject in a practical manner and as it has occurred to the writer, a few remarks on treatment. I believe that all accessible abscesses associated with an adherent liver are best dealt with by free incision, washing out with an antiseptic fluid, the introduction of a drainage-tube, and by antiseptic dressing.

The use of the abdominal bandage is sufficiently manifest as a means of preventing motion of the liver, and of holding it fixed, and needs no special comment. The medical treatment must be symptomatic. The writer believes that rest, a cool climate, and maintenance of the nutrition and strength of the patient, are the main

ends to be attained. The most important point is to secure an early and safe exit for the pus.

*Higest*

**ASEPTOL, THE NEW ANTISEPTIC.**—This new phenol compound has recently been brought to the notice of the profession under the name of ortho-oxyphenyl-sulphurous acid, a name which at a glance is intended to make clear its chemical composition. For greater convenience it has been decided to call it aseptol, a name derived from its property of completely destroying the lower forms of life.

Aseptol is said to possess properties which place it far in advance of any thing hitherto offered for like purposes.

It is said to be highly germicidal, to be but feebly caustic, to be abundantly soluble, to possess but a slight, not disagreeable odor, and, so far as experiment has gone, to be far less toxic than carbolic acid. To this last body it stands related in a chemical as well as germicidal sense, and is applicable to all the uses to which it is put. Furthermore, owing to the greater solubility and the comparative innocuousness of the aseptol, it will find many uses where the other body for obvious reasons, is wholly inapplicable.

Aseptol is described as being a viscous liquid of a slightly red color and of a specific gravity of 1.450; its odor suggests that of carbolic acid, but it is far more agreeable. It is supplied by Merck in a solution containing thirty-three and a third per cent of the substance, and in this form it is eligible for immediate use or for dilution to any desired strength. From the report of Drs. Leroy and Von der Shriek, of Antwerp, who studied quite extensively its therapeutic applications, the following table of advantages is derived:

1. It is very soluble in water.
2. It is very slightly caustic.
3. It is free from irritating qualities, and may be applied for a long time to the skin, the eyes, the bladder, etc.
4. Finally from its slight toxicity, which permits its use internally in considerable doses, and also the application of it in concentrated solutions to diphtheritic pharyngitis, and laryngitis, we anticipate for it a wide field of usefulness.

*Medical News*

**DISINFECTANTS FOR CLOTHING.**—In cases of smallpox, yellow fever, and some other contagious diseases, the clothing and bedding used by the patient while sick should be burned. In other cases, it may be disinfect-

ed by thoroughly baking in an oven. Beds should be thoroughly disinfected after every case of contagious disease.

The National Board of Health recommended a few years ago, for clothing, a solution made of four ounces of zinc sulphate and two ounces of common salt, to the gallon of water. The solution should be made boiling hot, and after the clothes have been placed in it, piece by piece, it should be kept boiling hot until it has permeated every portion of the clothing. If nothing else is possible, clothing which has been exposed should be *thoroughly* boiled before being used again.—*Druggists' Circular.*

**OSMIC ACID** is recommended by James Merces, M. R. C. S., in the Lancet, for sciatica. From three to five minims of a one-per-cent solution is injected by the hypodermic syringe deeply into the parts over the course of the nerve midway between the tuber ischii and the trochanter major. There may be slight numbness following. In some the effect was marvelous. Out of eighteen cases twelve were given relief for several weeks, when they passed from under observation.

**INTEMPERATE EATING.**—Two cases are reported in an exchange. The first is that of a railway clerk, who appeared well when he went to bed on a Sunday night, but died before morning. The medical man who examined the body found the stomach largely distended with undigested food, which had stopped the action of the heart. The other case was that of a negro from Sierra Leone in whose stomach whole potatoes were found.—*Druggist's Circular.*

**THE TREATMENT OF RINGWORM.**—In an article in the British Medical Journal, Mr. Alder Smith recommends a solution of chrysophanic acid in chloroform as an application to ringworm. The chloroform dissolves the fatty matter in the hair follicles, and thus allows the acid to get to the parasite. The hair should be closely clipped. The strength used is seven grains of the acid to the ounce of chloroform.

It is claimed that the disagreeable odor of turpentine oil may be disguised by an admixture of an equal part of oil of lemon.

**THE** annual meeting of the New York State Medical Society was held in Albany, February 3d, 4th, and 5th.

## The Louisville Medical News.

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### SCARLET FEVER PROGNOSTICS.

The appearance of a few cases of scarlatina maligna last week in the extreme western portion of Louisville gave rise to a scare in that locality, and through the weird word-pictures of some talented reporters of the daily press excited much concern among the parents of the little ones throughout the city.

The ominous words "Black Scarlatina" in heavy caps frowned threateningly from the top of the column, and doubtless brought to the minds of the cultured visions of the Black Death which wasted Europe in the fourteenth century, and to the simple folk the apparition of a destroying fiend escaped the pit with the dust of the infernal world unshaken from his plumes. The following well-meant, timely words from one of our prominent practitioners have served to quiet public fear, which so far as the implicated locality is concerned seems not to have been without foundation. He says:

It is not at all unusual for children dying from eruptive diseases to become dusky before and mottled after death. Such phenomena are as common after measles as after scarlatina. There is but one poison in these cases, and the community need have no fear that a new plague has been

started. There is no more danger from these cases than from others of less severity. In the first place, it should be known that scarlet fever and scarlatina are one and the same disease, for which there is one poison or germ, just as there is one measles poison and one smallpox poison. It is not presumed that a man has a less severe case of smallpox because he contracted it from mild case of varioloid, and, conversely, that a case of scarlatina contracted from a malignant case is not necessarily malignant. Malignancy and severity of cases most frequently depend upon some unknown constitutional peculiarity in the individual attacked. So the community need feel no more apprehension in regard to the Portland cases than any others of less severity, nor from any cases where due diligence and care are exercised by attention to personal cleanliness and disinfection by attendants.—*From the Louisville Evening Times, Feb. 7, 1885.*

Now, while most of the statements here made are not without the warrant of high authority, it must be admitted that the writer is somewhat too dogmatic upon certain mooted points, while he fails to take note of a prime factor in all prognostic calculations touching scarlatina.

In no disease are degrees of severity more marked than in scarlatina, which may range all the way from cases which scarcely interrupt the child at play to cases which develop in a few hours the gravest symptoms, with an inevitably fatal issue.

That these differences are simply of degree is possible, the specific poison being the same in every case, while constitutional peculiarities in the person attacked, as the writer avers, may account for mildness on the one hand and malignancy on the other; but nevertheless it can not be denied that the disease is almost universally malignant in some epidemics and quite benignant in others. It is still a moot point with observers as to whether these variations be due to degrees of virulence in the miasm, to local conditions, or to personal susceptibility. If the last hypothesis be urged, it must be admitted that this susceptibility is often owned in common by a great number of children scattered over wide areas. Touching these questions Alfred Loomis, in his recent work on Practice\*, says:

\*William Wood & Co., New York, 1884.

No reason can be assigned for its variations in type or severity. For years the type of fever which appears in a given locality will be exceedingly mild in character, when suddenly, without any assignable cause, a most malignant epidemic will prevail.

Again this author says :

The most frequent irregularity in the manifestation of the disease is noticed in that class of cases where we have complications resulting from the overwhelming of the cerebro-spinal system with the scarlatina poison. This is due to some peculiarity of the poison, and is characteristic of certain epidemics.

Further Dr. Loomis remarks :

The prognosis in scarlet fever will be influenced more by the character of the prevailing epidemic than by any other circumstance.

Thomas\*, while giving due weight to personal susceptibility, notes the fact that the disease prevails with a severity peculiar to or characteristic of a given epidemic. He ascribes the malignancy, however, to local conditions, and cites in proof of this the fact—

That scarlatina may infect neighboring localities in a mild and malignant manner at the same time. Thus Stiebel mentions the epidemic at Frankfort in 1816 as one of the mildest, while the same is described by Kopp, in the neighboring town of Hanau, as one of the severest.

Thomas says further :

The prognosis in by far the greater number of cases is chiefly determined by the character of the epidemic.

Frederick T. Roberts† says in the same connection :

The chief circumstances which render the prognosis grave are a severe epidemic type of the disease, etc.

Austin Flint‡ observes :

Richardson has advanced the opinion that the relative proportion of severe and mild cases is always about the same, viz., as one to five, there being a sufficiently large number of mild cases to equalize the ratio whenever the number of fatal cases is large. This opinion is opposed to common observation. The prevailing type of the disease in some seasons is mild and in other seasons se-

vere. Whether this variation be due to a difference in the virulence of the miasm or to adjunctive influences we are unable to say.

Eustace Smith\* says :

Different epidemics have different degrees of severity ; but, apart from the special type of fever prevalent, the intensity of the disease is dependent more upon the constitutional state and sanitary surroundings of the recipient than upon the severity of the disease in the person from whom the infection is conveyed.

In another place he says, under *Prognosis* :

The exact character the fever is to assume appears to depend upon the type of the epidemic and the constitutional peculiarities of the patient.

It would be easy to multiply quotations to the point, but the above are sufficient to show that, whatever may be said for or against individual susceptibility, the most eminent writers of the day agree in one thing, which is that the *prevailing type* of the disease must ever be taken into account in scarlatina prognostics; and this not only as to the probable issue in a given case but also as to the probable severity or mildness of an incoming endemic or epidemic.

The majority of the profession will certainly agree with the writer in question, "that a case of scarlatina contracted from a malignant case is not necessarily malignant," but that such a case (the prevailing type being severe) is much more likely to be malignant than it would be if contracted from a mild case (the prevailing type being mild), is a claim which finds support in innumerable observations.

It will be noticed that the authors here quoted lay much stress upon local conditions as a factor in determining the degree of severity which a given epidemic shall assume, and we know that the writer under review is too skillful a sanitarian to overlook this factor in a locality like Portland, a large part of which was laid under water by each of the spring freshets of the last two years. His statement therefore, that the "community need feel no more apprehension in regard to the Portland cases than any others of less se-

\*Ziemssen's Cyclopedie, Vol. II.

†Practice of Medicine: P. Blakiston, Son & Co., Philadelphia, 1884.

‡ Practice of Medicine: Henry C. Lea, Phila., 1868.

§ Disease in Children: William Wood & Co., New York, 1884.

verity," if intended for the whole city of Louisville, is a point certainly well taken; but if it be designed to meet the exigencies of the endemic at Portland the remark can not be said to accord with general professional experience.

But the object of this article is not to pass strictures upon what are probably some hastily-written statements by an esteemed friend and confrère, but rather to emphasize the importance of the prevailing type as a factor in the prognosis of individual cases of scarlatina, and to insist also that it shall be given due weight in all sanitary prophecies; that the physician and the health officer shall look upon the first cases of scarlatina in an endemic or epidemic as an earnest of those which are to follow, in the immediate neighborhood at least; and that, in case these show any sign of malignancy, the most radical sanitary measures which the law allows may be taken at once against the further spread of the disease.

**THANKS.**—For the life-like portrait of Dr. C. C. Graham, published last week, we are indebted to the courtesy of Mr. W. N. Haldeman, the distinguished president of the Louisville Courier-Journal Company.

### Bibliography.

**The Science and Art of Surgery.** A Treatise on Surgical Injuries, Diseases, and Operations. By JOHN ERIC ERICHSEN, F. R. S., L. L. D., F. R. C. S., Surgeon Extraordinary to Her Majesty the Queen, ex-President of the Royal College of Surgeons, England, etc. Eighth edition, revised and edited by Marcus Beck, M. S. and M. B., London, F. R. C. S., Surgeon to University College Hospital, etc. With 984 engravings on wood. Vol. I. Philadelphia: Henry C. Lea's Son & Co. 1884. For sale by John P. Morton & Co.

For many years this classic work has been made by the preference of teachers the principal text-book in surgery for the English and American medical students, while through translations into the leading continental languages it may be said to guide the surgical teaching of the civilized world.

In America especially has its influence been supreme, and the author shows his appreciation of the compliment paid him in the popularity of the work with us, by a graceful dedication of the present edition to the surgical profession of the United States.

As was clearly necessary by virtue of the recent rapid advance in all departments of surgery, the revision of the work has been thorough, and in some instances radical. In much of this, however, the author shows the wise conservatism, ever characteristic of one whose years have given him large experience, and whose skill has made effective and safe in his hands measures which have proved doubtful or dangerous in the practice of younger men. This may be illustrated by reference at random to a few questions which have of late been made matters of controversy.

In speaking of anesthetics, and the relative claims of chloroform and ether, the author says:

*As to applicability*, there can be no doubt that in the vast majority of cases both are equally applicable. . . Ether is preferable in those cases in which from severe shock the nervous powers are greatly depressed . . . and in atony of the heart, whether from fatty degeneration or from an enfeebled or dilated state of the ventricles. . . Chloroform appears more applicable in those cases in which it is necessary to maintain the anesthesia for a great length of time. . . In all abdominal surgery chloroform is preferable, as the violent respiratory movements that so commonly occur in consequence of the accumulation of mucus in the lungs and larynx during the administration of ether may prove a serious inconvenience to the surgeon. . . *As to convenience*: In this respect chloroform undoubtedly possesses a vast superiority over ether. . . Chloroform is infinitely more convenient than ether in many ways. *As to safety*: No anesthetic is absolutely safe. . . With ordinary care and some degree of experience the risk is capable of being reduced to very trifling proportions. But, slight as is the danger, . . there is still undoubtedly a certain definite peril attendant upon their use. That this is somewhat greater when chloroform is used than when ether is employed is generally acknowledged — how much greater is uncertain.

From the foregoing, it is evident that the author bears without taking sides the ether *versus* chloroform controversy, and finding chloroform practically safe and far more convenient in his hands, continues to use it in spite of the many deaths chargeable to its account. Like all other English surgeons (though he admits that it may be given through a hollow sponge), he seems to regard the inhaler as necessary to the effective administration of ether, and doubtless this delusion has operated much to the prejudice of this anesthetic in his hands.

In the matter of ligatures Mr. Erichsen does justice to all worthy candidates for favor, but states in unmistakable terms his preference for the catgut and silk. The gut of the silk-worm, the ox-aorta, and the silver wire find little or no favor with him.

The author, in his introduction, pays a handsome tribute to the doctrine of antisepsis, averring that it marks an epoch in surgery; but nevertheless his treatment of the question later in the work does not seem to show that he has been brought fully under its spell. He believes in cleanliness, and speaks in high terms of carbolic acid in the treatment of abscess and wounds, hinting that he sometimes makes use of the spray; he also makes respectful mention of iodoform, chloride of zinc, permanganate of potassium, boracic acid, thymol, etc., but in such a way as to betray a conservative attitude to this much-discussed and certainly mooted question.

After a somewhat careful, but not exhaustive search, we are unable to find any thing more than a passing reference to bichloride of mercury as an antiseptic or germicide, and this is a quotation from Robert Koch's detailed experiments upon the power of certain chemicals to destroy microbes. The author of course speaks in high praise of mercury as a therapeutic agent, and gives the usual rules and methods for its internal and external administration, but so far as we have searched his pages we find no case in which he advises the use of  $HgCl_2(1-1000)$ , or otherwise in the treatment of wounds or abscesses as an antiseptic or germicide. This would seem to be "the most unkindest cut of all," but possibly his pages were in the hands of the printer before the sublime was brought to the test in surgical practice.

The general character of the work needs no comment. Suffice it to say that in the scope of Vol. I no excellence of the former edition has been dropped, and no discovery, device, or improvement which has marked the progress of surgery during the last decade has been omitted. The illustrations are many, and executed in the highest style of the art. The editor has done his work critically and carefully, and as a disciple who keeps his master ever in view.

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Manual of Nervous Diseases and an introduction to Medical Electricity. By A. B. Arnold, M. D., Professor of Diseases of the Nervous system and Clinical Medicine,

College of Physicians and Surgeons, Baltimore, Md. With illustrations. New York: J. H. Vail & Co. 1885.

Annual report of the Supervising Surgeon-General of the Marine-Hospital Service of the United States for the fiscal year 1884. (U. S. Marine-Hospital Service.) Washington: Gov't. Printing Office. 1884.

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**A Practical Treatise on Diseases in Children.**  
By EUSTACE SMITH, M. D. Fellow of the Royal College of Physicians; Physician to His Majesty the King of the Belgians: Physician to the East London Children's Hospital, etc. New York: William Wood & Co. 1884. For sale by John P. Morton & Co.

That an English author of such distinction as Dr. Smith should make his longest and most thoughtful literary venture with an American publisher is a compliment to American medicine, and a worthy testimonial to the enterprise of the great house from which it issues.

The volume is an octavo, printed in long primer without leads, of 844 pages and 101 chapters. The author treats his subject systematically in twelve parts: Part first being devoted to the Acute Infectious Diseases; part second to General Diseases not Infectious; part third to Diathetic Diseases; part fourth to Diseases of the Ductless Glands and Blood; part fifth to Diseases of the Nervous System; part sixth to Diseases of the Organs of Respiration; part seventh to Diseases of the Heart; part eighth to Diseases of the Mouth and Throat; part ninth to Diseases of the Digestive Organs; part tenth to Diseases of the Liver; part eleventh to Diseases of the Genito-Urinary Organs, and part twelfth to Diseases of the Skin.

Thus it will be seen that nearly the whole nosological category is passed in review, with such limitations as the conditions of childhood demand. The book is not loaded down with reports of cases, statistics, or an elaborate bibliography, but every affection is philosophically handled, the author making good use of the observations of others when necessary, but in the main drawing upon his own great resources, which represent a practical study of more than twenty years' duration. This gives the work a decidedly original color, and they who seek its pages for information beyond that obtainable through current medical literature will not be disappointed.

While the pathology and symptomatology

of diseases of children are handled in a most satisfactory manner, it will be found that the author devotes the best part of his work to the all-important questions of the hygiene of young children, and the therapeutics of their peculiar ailments. In this he has been at much pains to note every medicine and detail of management which can in any way contribute to the success of the physician in so important a subdivision of his field of labor. The work is a noble one, and will long hold place among the classics of medical literature.

**A Manual of Dermatology.** By A. R. ROBINSON, M. B., L. R. C. P. and S., Edin.; Professor of Dermatology at the New York Polyclinic; Professor of Histology and Pathological Anatomy at the Woman's Medical College of the New York Infirmary, etc. New York: Birmingham & Co. 1884. For sale by John P. Morton & Co. Price, \$5.00.

In press-work and general appearance this is an elegant book, and seems on perusal to be in contents worthy of the pains bestowed upon it by the publishers. The author writes with ease and simplicity of diction, and shows himself to be an enthusiastic disciple of Hebra and Kaposi, while he repeats respectfully the conclusions of Wilson, McCall Anderson, and other English masters of his specialty. He seems, however, not to be on reflecting terms with our native dermatological lights, or at least has found in their writings, with the exception of Duhring's, little that served his purpose in the construction of the present work. He makes use of the classification of Hebra, and, in doing so, speaks in belittling terms of the classification adopted by the American Dermatological Association.

The work will prove interesting to the general practitioner, since the author is free of illustrations, clear in his statement of points bearing upon diagnosis, and simple, sensible, and scientific in his suggestions for treatment. The pathology of the work can not fail to interest the specialist. In this department the author is most happy, proving himself to be indeed a master of the subject.

**The Hygiene of the Nervous System and Mind.** By C. H. Hughes, M. D., St. Louis, Lecturer on Psychiatry and Neurology, St. Louis Medical College, etc. Reprint from the Alienist and Neurologist, St. Louis, January, 1885.

**Transactions of the American Dermatological Association:** Eighth Annual Meeting, held at Highland Falls, near West Point, New York, on the 27th, 28th, and 29th of August, 1884. Official Report of the Proceedings by the Secretary, W. T. ALEXANDER, A. M., M. D. New York. 1884.

This is a modest pamphlet of 26 pages. From its account the attendance at the meeting was small, but large enough to number the majority of the leading dermatologists in the country. The papers read were brief, and in every instance contained something new, striking, or suggestive in the pathology, clinical history, or treatment of the affections under discussion. The proceedings will find many appreciative readers among the general practitioners of the land.

## Societies.

### LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.

Stated meeting, January 23, 1885. J. W. Holland, A. M., M.D., President, in the chair.

Dr. Vance read a paper on treatment of cold abscess. (See page 100.)

Dr. Marvin reported a case of suppuration of a gland under angle of the jaw which had run a very protracted and troublesome course.

Dr. Vance stated that he frequently treated such cases by aspiration, washing them out thoroughly, for which purpose a counter opening was made to give exit to pus and injected fluids.

Dr. von Donhoff stated that when a gland began to suppurate it would continue to do so until the entire gland was destroyed, so he considered it best to remove the gland by enucleation or by the cautery.

Dr. Bailey wished to know to what glands Dr. von Donhoff had reference in his remarks, and if he meant to make the same statement with regard to the mammary gland, the liver, etc.

Dr. von Donhoff stated that he had had reference more particularly to lymphatic glands. The mammary gland he stated was divided into a number of lobes by a condensation of connective tissue, and that an abscess of this gland destroyed completely all the lobes affected so that in subsequent pregnancies scarcely any milk is furnished on account of the atrophy following the abscess.

As for abscess of the liver he believes

that it almost invariably terminates in death sooner or later. As for lymphatic glands, when they once begin to suppurate they invariably continue to do so until the entire gland is destroyed.

Dr. Scott maintained that a large per cent of lymphatic-gland suppurations are due to constitutional causes, generally to scrofula, and that proper medication will frequently render operative procedure unnecessary.

Dr. Vance reported a case where a lymphatic gland of the neck suppurated and the abscess was opened by the knife, leaving a very ugly zig-zag scar. Sometime afterward a similar gland on the other side of the neck went on to suppuration, the patient then applying to Dr. Vance. The abscess was aspirated, leaving only a very small white scar.

Dr. Cottell spoke in favor of iodine in scrofulous glandular affections, and expressed his preference for iodized horse-radish or sodium iodide in such cases. He stated that all salts of potassium had been shown to be poisonous, and that they exerted a deleterious influence on the blood when given for any length of time.

Dr. Cartledge stated that he had frequently had very good results from the use of small tonic doses of mercury (one tenth grain of bichloride) in scrofulous children.

Dr. Marvin exhibited a microscopical specimen of the spinal cord of a man who died from a fracture of the fourth cervical vertebra, sustained in a railroad accident, showing a hemorrhage into the cord.

Dr. Cottell. This case is interesting from a physiological point of view, as the spinal accessory which furnishes laryngeal filaments to the vagus comes off from the cord at the fifth cervical vertebra; Dr. Marvin's patient had paralysis of the vagus; it would be interesting to note whether this was partial or complete.

Dr. Wilson reported a case of aneurism of ascending portion of the arch of the aorta which, by its pressure, had destroyed a part of the sternum so that it was only covered by the skin. No difference was noticed in the pulse at the two wrists.

Dr. Roberts reported several cases of hernia, one case occurred in a man who had had a hernia for some time which descended whenever he strained himself. While carrying a trunk it became extruded. Patient had vomited twice when seen. Movement caused pain, pulse eighty. An unsuccessful attempt at reduction was made under

chloroform. Drew off fluid from the sack with a hypodermic syringe but still it could not be reduced. Patient was put to bed so as to get the benefit of gravity.

When seen the next morning the temperature was 100° and the patient had vomited frequently during the night. On operating the hernia was found to consist of omentum and intestine. The omentum which was found in the sack was almost black, and was cut off. The intestine was found to be unaffected. The case ended fatally.

Mr. W., had a hernia for sixteen years and had been wearing a truss. On descending the steps he suffered from pain which caused him to go to bed. His bowels became constipated and distended with gas. Patient was nauseated but had not vomited. Tongue dry and coated. Temperature and pulse normal. Patient was operated on and a strangulated hernia was found, the sack being removed. The sack had a small secondary sack containing pus. Patient made a good recovery.

Another case was in an old lady sixty-five years of age, very thin. She had had a double hernia for some time but had not worn a truss. A few days ago the hernia came down and ineffectual attempts were made at its reduction. The hernia had merely become irreducible but was not strangulated. In a few days symptoms of inflammation made their appearance. On operating the sac was found to contain intestine and omentum, and about a half ounce of bloody serum. The sac was more inflamed than the contents. Patient made a good recovery.

No. 4. occurred in a man who had had a hernia for some time and was wearing a truss. During sexual intercourse the truss came off, and as it was not immediately replaced the hernia descended. Considerable difficulty was found in reduction.

Dr. Cottell reported the successful use of paraldehyde in a case of mania where the patient was sleepless and violent after taking large doses of bromide of sodium.

Dr. Roberts reported that he had failed to get any effect after using two ounces of the elixir of paraldehyde in a similar case.

R. MAUPIN FERGUSON,  
*Secretary.*

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A BILL to regulate the practice of medicine in the State of New York was introduced into the Assembly on the 27th January.

## Correspondence.

### PARIS LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

In his thesis for the doctorate, on epilepsy in its relation with pregnancy and parturition, Dr. R. Beraud, a pupil of Professor Ball, makes some very interesting observations on the subject, and the following are the conclusions of his thesis: Pregnancy is not a cause of epilepsy; uterine epilepsy of the ancients is the eclampsia of the modern writers. The influence of pregnancy on pre-existing epilepsy may be favorable, unfavorable, or nil; favorable, if it entirely suspends the attacks, or only diminishes the number; unfavorable, when the attacks are increased in frequency. In general the peculiar characteristics are not modified; the form and intensity of the attacks remain the same. The cases in which the influence of pregnancy is favorable are the greater number. In the same woman the influence of pregnancy is stereotyped, uniform; that is to say that which it was in a first pregnancy it will always be in the subsequent pregnancies. The modifying action of pregnancy is generally of a temporary character and is limited to the duration of gestation; in other words, the ulterior progress of the epilepsy is not modified. There does not appear to exist a collection of precise conditions, clearly determined, which would foreshadow the character of the modifications which pregnancy is susceptible of impressing on the epilepsy. Parturition is not a cause of epilepsy. The influence of parturition on pre-existing epilepsy is nil. In the exceptional cases where labor comes on in a convulsive fit, the influence of the attacks of epilepsy on the uterine contractions appear to be nil. Marriage does not cure epilepsy; it aggravates it. Bromuration, which is useful to the mother, is not injurious to the infant. Epilepsy does not appear to predispose the subject to eclampsia.

In a work by Dr. Muselli, of Bordeaux, on enteroclysm he points out the great utility of this method of treatment in several cases which are considered more or less intractable. He describes the enteroclysm as an instrument designed to inject different liquids into the intestines. It is composed of a metallic vessel capable of containing two liters of fluid. To the body of this pump is adapted an india-rubber tube of

four or five meters in length, at the extremity of which is fitted a pipe of twenty-five or thirty centimeters long, and is also provided with a tap. In fact the enteroclysm is the ordinary French irrigator or syringe considerably increased in size. The force of the fluid injected by the enteroclysm is far greater than that of any other syringe, or even than that of the seltzer-water syphon bottles, which are sometimes resorted to in similar cases, as with the enteroclysm the liquids have been known to reach the small intestines and even the stomach. In some cases the liquid injected by the anus has been vomited by the mouth. The employment of the instrument is simple enough; it is suspended filled with the liquid for injection, at the height of a few feet above the level of the patient; the patient, either in a sitting posture or lying in his bed, introduces the pipe into the rectum and opens the tap.

The following are some of the cases in which Dr. Muselli employed the instrument with apparent success: (1) Nervous affections of the intestines or what is termed intestinal dyspepsia. This affection, is due to the passage from the stomach to the intestine of badly prepared chyme, which soon ferments. The pain which accompanies this dyspepsia is dependent on the nervous system. The washing out of the stomach with the stomach-pump containing an alkaline or other liquid is unbearable to certain subjects. This can not be said of the enteroclysm, which has the advantage of completely emptying the entire tract of the intestinal canal. The nervous spasm of the intestine is modified by enteroclysm. Constipation independent of an affection of the nervous centers, and having for cause a local malady of the intestine, is also cured by enteroclysm. (2) In congestive and inflammatory affections of the intestine, such as simple enteritis, ulceration of the mucous membranes of the intestines in dysentery and typhoid fever, enteroclysm is invaluable, as by its means the intestines are thoroughly cleared of all offending matter, and instead of administering by the mouth the various preparations used in such cases they may be preferably introduced directly into the intestine. (3) In intestinal occlusion, enteroclysm is a great resource as a remedial agent. The author cites several cases of cure by this means. (4) For feeding by the rectum enteroclysm is preferable to simple enemata, as by the latter no more

than fifty or sixty grams of fluid can be injected into the rectum at a time, whence the necessity for repeating these enemata several times in the day, which ends by producing irritation of the anus and rectum. Moreover, the nutritive fluids introduced only into the rectum do not undergo the phenomena of digestion, whereas with the enteroclysm a much larger quantity of alimentary fluid can be introduced and pushed much farther into the intestine, where it would be in direct contact with the digestive fluids. As a precautionary measure the liquid to be injected may be rendered lukewarm, and previously submitted to the action of pepsin or the gastric juice of animals. In the divers cases where the introduction of alimentary substances by the mouth is impossible (tetanus paralysis of the muscles of deglutition etc.) the necessary quantity of water may be furnished to the organism by enteroclysm. The author then points out the great utility of enteroclysm in the following circumstances: In impassable stricture of the esophagus, enteroclysm should be employed before resorting to gastrostomy. Should the stricture be of a cancerous nature, gastrostomy and enteroclysm may be utilized at the same time. If the stricture is the result of an ulceration or of syphilitic gumma, enteroclysm may be resorted to for the administration of the iodide of potassium and of alimentary substances by enemata. Gastrostomy should be resorted to only in case of failure by the above treatment. In stricture resulting from the swallowing of caustic substances, enteroclysm will often be found sufficient to keep up the strength of the patient and thus defer the necessity for gastrostomy for an indefinite time. In cases of cancer of the pylorus, enteroclysm is preferable to gastrectomy. In grave dyspeptic troubles caused by anemia enteroclysm should be tried before having recourse to transfusion of blood proposed in these cases.

The writer of this letter would suggest the employment of enteroclysm in cholera as he considers that it would render invaluable service in that most mysterious and terrible malady.

PARIS, January 23, 1885.

Some original and translated articles are crowded out of this issue, the appearance of which the authors had reason to expect. Our next will contain them.

## Translations.

**EVERY MAN HIS OWN LIFE PRESERVER.\*** M. Sylvester, the doctor so well known by his studies of the treatment of those who have been drowned, has recently made some experiments very original in the insufflation of air in the subcutaneous cellular tissue. By this means he has succeeded in rendering animals capable of floating in water without effort, and he thinks the procedure may be made of service to man. In 1883 he introduced into the subcutaneous cellular tissue of a cadaver a quantity of air sufficient not only to prevent it from sinking but also sufficient to support a weight of about twenty kilograms (fifty pounds). It is only necessary to make a small incision at the wrist, and to introduce under the skin the point of a tube which is to be connected with a syringe.

Since then M. Sylvester has been seeking some more simple and practicable means of accomplishing this on the living.

The following is the original procedure which he has adopted: A small puncture is made in the mucous membrane of the mouth, opposite the first inferior molar tooth, with a penknife. It is necessary to introduce the knife sufficiently deep to perforate the superficial aponeurosis without wounding the skin. The instrument is then withdrawn, and closing the mouth and holding the nostrils closed, violent efforts at expiration are made. The air in the mouth, being strongly compressed, penetrates by the small wound into the subcutaneous connective tissue, and extends over the neck and breast down to the nipples. The time necessary for the procedure is not more than three minutes. To prevent the escape of the air, pressure may be made with the finger on the skin corresponding to the puncture, or the jaws may be kept distended with air. The operation causes only an insignificant degree of pain, and gives rise to no disagreeable accidents. The quantity of air thus forced into the subcutaneous connective tissue is sufficient to support thirteen pounds (five kilograms) in water. The human body is thus rendered incapable of sinking. M. Sylvester believes that this procedure, so strange in appearance, is capable of rendering much service in cases of shipwreck. To allow the air to escape, pressure is removed from the small opening and a few efforts are made at suction.

\*Translated from *La Semaine Médicale* by R. Maupin Ferguson, M. D.

## Selections.

**TREATMENT OF SPRAIN BY THE ELASTIC BANDAGE.**—This method of treating sprains has recently been recommended by Marc See. It is the only method which fulfills the two indications: (1) To cause as rapid absorption as possible of the blood extravasated around the joint (a lesion which controls all the other symptoms, such as pain, swelling, difficulty of movement, etc.); and, (2) To favor cicatrization of the torn ligaments and ruptured parts by complete immobilization.

The antiphlogistics and blood-letting formerly advised by Hunter and Guersant only partially fulfill the former indication. There are the same objections to the movements which Ribe and Bonnet advise for the injured joint. The refrigerants and cold-water baths advised by Baudens cause contraction of the tissues around the joint, and dispel the inflammation, but they are not favorable to the absorption of the infiltrated fluids. Even massage, though superior to the other remedies just mentioned, fulfills only the second indication; furthermore, it is inconvenient, and requires much patience and time; and between the manipulations the swelling reappears and the pain returns. It is true that massage has the advantage of removing the extravasated materials from the region of the joint toward the more vascular portion of the limb, where they are more easily absorbed. But the elastic bandage has this advantage in a greater degree, since its action is continuous. Finally, and above all, it favors immobilization of the joint, which is impossible during massage, and without which it is almost impossible to get cicatrization of the torn structures and complete recovery in sprains of any intensity. The bandage should be applied to the skin itself, care being taken to fill up the flat and depressed places with wadding, so as to give a uniform surface around the joint for the bandage to act upon.—*Revue de Therap.; Practitioner.*

**BEECH-CREASOTE IN PULMONARY AFFECTIONS.**—Dr. Lasinee recommends a combination of creasote, balsam of tolu, and Norway tar in the treatment of pulmonary affections. He gives the following formula: Pure beech-creasote, 1 minim; purified Norway tar, balsam of tolu, each, 1.5 minim. Inclose in a capsule. In incipient phthisis, two such capsules should be given

morning and evening. In advanced cases the number of capsules may be increased to twelve daily.—*New York Med. Journal.*

**IDOFORM IN ORGANIC DISEASES OF THE HEART.**—Professor Testa, of Messiana, has employed with success the treatment recommended by Moleschott for the relief of functional disturbances in incurable disease of the heart. This consists in giving seven centigrams of iodoform in four pills daily, continuing it for some time, this lasting in one patient for nearly a month. It acts especially by diminishing the number of the beats of the heart and increasing arterial tension.—*Gazette des Hôp.; Medical Times and Gazette.*

### ARMY MEDICAL INTELLIGENCE.

**OFFICIAL LIST** of Changes in the Stations and Duties of Officers serving in the Medical Department of the United States Army, from February 1, 1885, to February 7, 1885:

*Waters, William E.*, Major and Surgeon, granted leave of absence for one month. (S. O. 24, Dept. East, Jan. 31, 1885.) *Wilson, William J.*, Captain and Assistant Surgeon, ordered for duty as Post Surgeon, Fort Preble, Me. (S. O. 27, Dept. East, Feb. 5, 1885.) *Woodruff, Ezra*, Captain and Assistant Surgeon, ordered from Willet's Point, New York Harbor, to Dept. of Dakota. *Taylor, Marcus E.*, Captain and Assistant Surgeon, ordered to Dept. of the Missouri. (S. O. 30, A. G. O., Feb. 5, 1885.)

**OFFICIAL LIST** of Changes in the Stations and Duties of Medical Officers of the United States Marine Hospital Service, from January 1 to 31, 1885:

*Stoner, G. W.*, Surgeon. When relieved to proceed to Washington, D. C., for duty as Chief of Purveying Division, Jan. 16, 1885. *Benson, J. A.*, Passed Assistant Surgeon. When relieved to proceed to Chicago, Ill., for duty, Jan. 12, 1885. *Carmichael, D. A.*, Passed Assistant Surgeon. When relieved to proceed to Cairo, Ill., for duty, Jan. 3, 1885. *Ames, K. P. M.*, Passed Assistant Surgeon. When relieved to proceed to New York, N. Y., for duty, Jan. 14, 1885. *Urquhart, F. M.*, Passed Assistant Surgeon. To proceed to Norfolk, Va., and assume charge, Jan. 12, 1885. *Brooks, S. D.*, Assistant Surgeon. To proceed to Evansville, Ind., and assume charge, Jan. 14, 1885. *Carrington, P. M.*, Assistant Surgeon. To report to Surgeon-in-Charge, St. Louis, Mo., for temporary duty, Jan. 17, 1885.

**PROMOTION.**—*Stoner, G. W.*, Surgeon, promoted and appointed Surgeon by the Secretary of the Treasury from Jan. 16, 1885, Jan. 14, 1885.

**APPOINTMENT.**—*Carrington, Paul M.*, M. D., of Georgia, having passed the examination required by the regulations, was appointed an Assistant Surgeon by the Secretary of the Treasury, Jan. 16, 1885.